		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039503

Facility Name: ODIN HEALTHCARE CENTER

Address: 300 N. GREEN STREET (Number) ODIN (City) 62870 (Zip Code)

County: MARION

Telephone Number: (618) 775-6404 **Fax #** (618) 775-6404

IDPA ID Number: 351921817003

Date of Initial License for Current Owners: 06/07/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cathy Simeoni **Telephone Number:** (714) 596-7713, Ext 12

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) LINDA HOLTZSCHEITER
(Title) REIMBURSEMENT MANAGER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Cathy Simeoni, Manager - Healthcare Consulting
(Firm Name & Address) Kellogg & Andelson, Accountancy Corporation, 16162 Beach Blvd, #308, Huntington Beach, CA 92647
(Telephone) (714) 596-7713 Fax # (714) 596-7721

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	33	Skilled (SNF)	33	12,045	1
2		Skilled Pediatric (SNF/PED)			2
3	66	Intermediate (ICF)	66	24,090	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,453	900	3,772	8,125	8
9	SNF/PED					9
10	ICF	17,021	3,045		20,066	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,474	3,945	3,772	28,191	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.02%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/07/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/07/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 3,771

Medicare Intermediary AdminaStar, Illinois

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	138,754	9,061	9,836	157,651		157,651		157,651			1
2	Food Purchase		112,086		112,086		112,086		112,086			2
3	Housekeeping	86,390	5,954		92,344		92,344		92,344			3
4	Laundry	30,012	11,131		41,143		41,143		41,143			4
5	Heat and Other Utilities			87,495	87,495		87,495	302	87,797			5
6	Maintenance	26,206	19,118	23,422	68,746		68,746	142	68,888			6
7	Other (specify):*											7
8	**TOTAL General Services**	281,362	157,350	120,753	559,465		559,465	444	559,909			8
	B. Health Care and Programs											
9	Medical Director			6,100	6,100		6,100		6,100			9
10	Nursing and Medical Records	849,886	82,686	23,666	956,238		956,238	8,741	964,979			10
10a	Therapy	195,579	488	6,979	203,046		203,046		203,046			10a
11	Activities	28,737	4,020	2,137	34,894		34,894		34,894			11
12	Social Services	26,363		2,137	28,500		28,500		28,500			12
13	Nurse Aide Training											13
14	Program Transportation			2,423	2,423		2,423		2,423			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,100,565	87,194	43,442	1,231,201		1,231,201	8,741	1,239,942			16
	C. General Administration											
17	Administrative	59,260			59,260		59,260		59,260			17
18	Directors Fees											18
19	Professional Services			9,968	9,968		9,968	2,984	12,952			19
20	Dues, Fees, Subscriptions & Promotions			6,600	6,600		6,600	93	6,693			20
21	Clerical & General Office Expenses	71,206	10,734	81,039	162,979		162,979	27,273	190,252			21
22	Employee Benefits & Payroll Taxes			267,315	267,315		267,315		267,315			22
23	Inservice Training & Education			301	301		301		301			23
24	Travel and Seminar			13,862	13,862		13,862	9,287	23,149			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			70,330	70,330		70,330	(36,492)	33,838			26
27	Other (specify):*											27
28	**TOTAL General Administration**	130,466	10,734	449,415	590,615		590,615	3,145	593,760			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,512,393	255,278	613,610	2,381,281		2,381,281	12,330	2,393,611			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ODIN HEALTHCARE CENTER #0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			59,610	59,610		59,610	113,182	172,792			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(202)	(202)		(202)		(202)			32
33	Real Estate Taxes			43,700	43,700		43,700		43,700			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			688	688		688		688			35
36	Other (specify):* H/O SEE ATTACHED							15,289	15,289			36
37	**TOTAL Ownership**			103,796	103,796		103,796	128,471	232,267			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,281	12,514	91,795		91,795		91,795			39
40	Barber and Beauty Shops			10,127	10,127		10,127	10,127	20,254			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*			3,449	3,449		3,449		3,449			43
44	**TOTAL Special Cost Centers**		79,281	80,293	159,574		159,574	10,127	169,701			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,512,393	334,559	797,699	2,644,651		2,644,651	150,928	2,795,579			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(25)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,150)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	53,149			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 27,974		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	122,954		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 122,954		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 150,928		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ODIN HEALTHCARE CENTER

ID# 0039503

Report Period Beginning: 1/1/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Open House Expense	$ (1,111)	21	1
2	Other sales tax	(759)	21	2
3	Memorium/Benevolence Expense	(779)	21	3
4	Barber and Beauty	10,127	40	4
5	Vending Receipts	(1,141)	21	5
6	Misc Receipts	(502)	21	6
7	Depreciation Reconciliation	(8,626)	30	7
8	FAS 121 Depreciation Adjustment **	121,808	30	8
9	Professional Liability Insurance	(34,611)	26	9
10	Marketing Wages	(31,257)	21	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19	**The facility re-valued their assets in 1999. We			19
20	have reported the historical costs of the assets			20
21	consistent with the prior years, and have ensured			21
22	that depreciation expense is reported on straight			22
23	line. This adjustment is necessary to reverse the			23
24	re-valuation of historical cost.			24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	53,149		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	302	0	0	0	0	0	0	0	0	0	302	5
6	Maintenance	0	142	0	0	0	0	0	0	0	0	0	142	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	444	0	0	0	0	0	0	0	0	0	444	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	8,741	0	0	0	0	0	0	0	0	0	8,741	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	8,741	0	0	0	0	0	0	0	0	0	8,741	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,984	0	0	0	0	0	0	0	0	0	2,984	19
20	Fees, Subscriptions & Promotions	0	93	0	0	0	0	0	0	0	0	0	93	20
21	Clerical & General Office Expenses	(60,724)	87,997	0	0	0	0	0	0	0	0	0	27,273	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	9,287	0	0	0	0	0	0	0	0	0	9,287	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(34,611)	(1,881)	0	0	0	0	0	0	0	0	0	(36,492)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(95,335)	98,480	0	0	0	0	0	0	0	0	0	3,145	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(95,335)	107,665	0	0	0	0	0	0	0	0	0	12,330	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **ODIN HEALTHCARE CENTER** **#** **0039503** **Report Period Beginning:** **1/1/01** **Ending:** **12/31/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**TOTALS (to Sch V, col.7)**	
30	Depreciation	**113,182**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**113,182**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**32**
33	Real Estate Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**34**
35	Rent-Equipment & Vehicles	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**
36	Other (specify):*	**0**	**15,289**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**15,289**	**36**
37	**TOTAL Ownership**	**113,182**	**15,289**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**128,471**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**38**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**
40	Barber and Beauty Shops	**10,127**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**10,127**	**40**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**41**
42	Provider Participation Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**
43	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**
44	**TOTAL Special Cost Centers**	**10,127**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**10,127**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**27,974**	**122,954**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**150,928**	**45**

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Post Acute Network	100	See Attached Pg 6.1		Mariner Post Acute Network	Atlanta, GA	Bookkeeping & Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Post Acute Network	100.00%	$ 302	$ 302	1
2	V	6	Repairs and Maintenance		Mariner Post Acute Network	100.00%	142	142	2
3	V	19	Professional Services		Mariner Post Acute Network	100.00%	2,984	2,984	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Post Acute Network	100.00%	93	93	4
5	V	10	Nursing and Medical Records		Mariner Post Acute Network	100.00%	8,741	8,741	5
6	V	21	Clerical and General Office Exp		Mariner Post Acute Network	100.00%	87,997	87,997	6
7	V	24	Travel and Seminar		Mariner Post Acute Network	100.00%	9,287	9,287	7
8	V	26	Insurance Premium		Mariner Post Acute Network	100.00%	(1,881)	(1,881)	8
9	V	36	Depreciation		Mariner Post Acute Network	100.00%	10,705	10,705	9
10	V	36	Taxes-Property		Mariner Post Acute Network	100.00%	449	449	10
11	V	36	Rental & Leasing		Mariner Post Acute Network	100.00%	2,704	2,704	11
12	V	36	Lease Expense		Mariner Post Acute Network	100.00%	1,430	1,430	12
13	V	36	Property Insurance		Mariner Post Acute Network	100.00%	1	1	13
14	Total			$			$ 122,954	$ * 122,954	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4	NOT APPLICABLE										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Post Acute Network
Street Address: One Ravine Dr., Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: (770) 379-8203
Fax Number: (770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Facility Costs			$ 20,767	$		$ 302	1
2	6	Repairs and Maintenance	Facility Costs			9,731			142	2
3	19	Professional Services	Facility Costs			205,127			2,984	3
4	20	Fees, Subscriptions, Promotions	Facility Costs			6,427			93	4
5	10	Nursing and Medical Records	Facility Costs			67,554			8,741	5
6	21	Clerical and General Office Exp	Facility Costs			6,582,242			87,997	6
7	24	Travel and Seminar	Facility Costs			638,416			9,287	7
8	26	Insurance Premium	Facility Costs			(129,286)			(1,881)	8
9	36	Depreciation	Facility Costs			735,846			10,705	9
10	36	Taxes-Property	Facility Costs			30,882			449	10
11	36	Rental & Leasing	Facility Costs			185,889			2,704	11
12	36	Lease Expense	Facility Costs			98,311			1,430	12
13	36	Property Insurance	Facility Costs			76			1	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 8,451,982	$		$ 122,954	25

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	35,390	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	43,844	2
3. Under or (over) accrual (line 2 minus line 1).	$	8,454	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	35,246	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	43,700	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	37,088	8
1997	37,431	9
1998	41,274	10
1999	42,472	11
2000	43,844	12

2001 Real Estate Tax Accrual - $35,246

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ODIN HEALTHCARE CENTER COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0039503

CONTACT PERSON REGARDING THIS REPORT Cathy Simeoni

TELEPHONE (714)596-7713 Ext. 12 FAX #: (714)596-7721

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-11-400-001	00000000 PT SE SE	$ 43,843.82	$ 43,843.82
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 43,843.82	$ 43,843.82

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,500 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	269,000	1994	$ 80,743	1
2					2
3	TOTALS	269,000		$ 80,743	3

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1994	1975	$ 3,360,767	$ 96,022	35	$ 96,022	$	$ 726,836	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvement Type**			1994	782,958	39,148	20	39,148		295,244	9
10	SEE ATTACHED - See page 12.1			1996	819	41	20	41		216	10
11	REPAIR SIDEWALK			1996	16,378	819	20	819		5,658	11
12	ROOFTOP A/C - See page 12.2			1997	2,845	142	20	142		689	12
13	INSTALL AWNING			1997	1,388	69	20	69		390	13
14	WATER HEATER - See page 12.2			1997	6,645	332	20	332		1,890	14
15	WATER HEATER INSTALL - See page 12.2			1998	357	9	20	9		36	15
16	ELECTRICAL			1998	1,516	38	20	38		152	16
17	HVAC			1998	2,853	71	20	71		284	17
18	PLUMBING			1998	3,885	97	20	97		388	18
19	WATER HEATER					86,553			(86,553)		19
20	RECONCILING ADJUSTMENT TO WTB 1998			1999	1,818	182	10	182		546	20
21	A.O. SMITH 75 GAL GAS			2000	1,397	140	10	140		233	21
22	100G GAS WATER HEATER			2000	8,579	572	15	572		858	22
23	12: ZONELINE HVAC UNITS			2000	1,224	122	10	122		204	23
24	FIRST Q DIGITAL RESET			2000	3,817	382	10	382		509	24
25	W/G & MAGLOCKS SYSTEM			2000	9,899	990	10	990		1,237	25
26	2200 SQ FT FLATROOF DOWN PYMT			2000	11,072	1,107	10	1,107		1,384	26
27	ROOF SHINGLES, 18000 SQ FT			2000	3,615	362	10	362		603	27
28	WANDERGUARD SYSTEM										28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Instl 11,220 SqFt Flat Roof	2001	$ 20,098	$ 2,010	10	$ 2,010	$	$	37
38	Roof Shingles-33% Down Pymt	2001	18,277	1,523	10	1,523			38
39	Balance of Roof Rcplcmnt	2001	36,553	2,742	10	2,742			39
40	9:Smoke & 2:Heat Detectors	2001	960	72	10	72			40
41	Use Tax-9:Smoke, 2:Heat Detectors	2001	62	5	10	5			41
42	R/T 3T Armstrong Condense Inst	2001	1,278	57	15	57			42
43	4:Maglocks & Indoor Keypads	2001	3,057	229	10	229			43
44	7:Zoneline HVAC-Patient Rooms	2001	4,718	131	15	131			44
45	Use Tax-7 Zoneline HVAC Units	2001	298	8	15	8			45
46	Charge Back-Excessive Discount	2001	442	10	15	10			46
47	5:Catch-All Digital Reset	2001	1,577	105	10	105			47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,309,152	$ 234,089		$ 147,536	$ (86,553)	$ 1,037,357	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 243,280	$ 24,603	$ 24,603	$		$ 140,269	71
72	Current Year Purchases	7,088	652	652			652	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 250,368	$ 25,255	$ 25,255	$		$ 140,921	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,640,263	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 259,345	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 172,792	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (86,553)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,178,278	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Overhead Allocation - Improvements	$ 2,579	$ 129	$ 656	86
87	Overhead Allocation - Improvements	1,035	52	230	87
88	Overhead Allocation - Improvements	117	6	25	88
89					89
90					90
91	TOTALS	$ 3,731	$ 187	$ 911	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 688 Description: Lease Exp - Eqpt - Nonmedical
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		1150 hrs	$ 22,946		$	$	1,150	$ 22,946	1
2	Licensed Speech and Language Development Therapist		729 hrs	15,550				729	15,550	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		1114 hrs	30,980			23	1,114	31,003	4
5	Physician Care		visits							5
6	Dental Care		visits			3,420			3,420	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts		211	9,072	79,281	211	88,353	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Audiologist					22			22	13
14	TOTAL			$ 69,476	211	$ 12,514	$ 79,304	3,204	$ 161,294	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ODIN HEALTHCARE CENTER **#** 0039503 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/01 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 900	$	1
2	Cash-Patient Deposits	34,397		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	511,817		3
4	Supply Inventory (priced at)	11,386		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 558,500	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	829,386		13
14	Buildings, at Historical Cost	1,533,472		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	96,422		16
17	Accumulated Depreciation (book methods)	(688,001)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,771,279	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,329,779	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 367,864	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	120,722		30
31	Accrued Taxes Payable (excluding real estate taxes)	817		31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,246		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SEE ATTACHED SCHEDULE 17.1	81,953		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 606,602	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	SEE ATTACHED SCHEDULE 17.1	5,713,058		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,713,058	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,319,660	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,989,881)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,329,779	$	48

***(See instructions.)**

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,740,200)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,740,200)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	743,176	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 743,176	17
	B. Transfers (Itemize):		
18	**Intercompany**	7,143	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 7,143	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,989,881)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,493,654	1
2	Discounts and Allowances for all Levels	(1,124,600)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,369,054	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	667,432	6
7	Oxygen	42,893	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 710,325	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	11,896	13
14	Non-Patient Meals	(141)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	150,185	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	126,550	19
20	Radiology and X-Ray		20
21	Other Medical Services	18,313	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 306,803	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine	1,141	28
28a	Miscellaneous Receipts	502	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,643	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,387,825	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	559,466	31
32	Health Care	1,231,201	32
33	General Administration	590,613	33
	B. Capital Expense		
34	Ownership	103,796	34
	C. Ancillary Expense		
35	Special Cost Centers	105,370	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,644,649	40
41	**Income before Income Taxes (line 30 minus line 40)****	743,176	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 743,176	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,083	2,253	$ 48,866	$ 21.69	1
2	Assistant Director of Nursing	929	1,005	17,216	17.13	2
3	Registered Nurses	12,265	13,265	212,087	15.99	3
4	Licensed Practical Nurses	11,162	12,072	160,241	13.27	4
5	Nurse Aides & Orderlies	44,660	48,303	399,036	8.26	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,033	4,362	96,549	22.13	7
8	Rehab/Therapy Aides	4,995	5,403	101,084	18.71	8
9	Activity Director	1,818	1,967	16,891	8.59	9
10	Activity Assistants	1,772	1,916	12,677	6.62	10
11	Social Service Workers	1,906	2,062	24,481	11.87	11
12	Dietician					12
13	Food Service Supervisor	1,719	1,860	21,626	11.63	13
14	Head Cook	5,668	6,131	51,234	8.36	14
15	Cook Helpers/Assistants	8,220	8,890	65,576	7.38	15
16	Dishwashers					16
17	Maintenance Workers	2,627	2,841	27,582	9.71	17
18	Housekeepers	11,552	12,494	86,962	6.96	18
19	Laundry	4,293	4,643	30,022	6.47	19
20	Administrator	2,018	2,182	52,708	24.16	20
21	Assistant Administrator					21
22	Other Administrative	2,008	2,172	25,218	11.61	22
23	Office Manager					23
24	Clerical	1,553	1,680	15,980	9.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,928	2,085	15,100	7.24	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	2,078	2,247	31,257	13.91	33
34	TOTAL (lines 1 - 33)	129,287	139,833	$ 1,512,393 *	$ 10.82	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	193	$ 7,897	1-3	35
36	Medical Director	76	6,000	9-3	36
37	Medical Records Consultant	69	2,448	10-3	37
38	Nurse Consultant	193	8,741	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	2,137	11-3	44
45	Social Service Consultant	36	2,137	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	603	$ 29,360		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Roxann D Summers	Administrator	0	$ 59,260
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,260

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached Invoices	Legal Fees	$ 9,968
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 9,968

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,370
Unemployment Compensation Insurance	18,683
FICA Taxes	112,602
Employee Health Insurance	88,133
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	7,527
TOTAL (agree to Schedule V, line 22, col.8)	$ 267,315

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Other License Fees	759
Dues	5,641
Home Office Allocation	93
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,693

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	13,844
Home Office Allocation	9,287
Seminar Expense	
Entertainment Expense	18
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,149

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ODIN HEALTHCARE CENTER # 0039503 Report Period Beginning: 1/1/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTHCARE ASSOCIATION**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,203**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **NO** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.